2016-2017 SATISFACTORY ACADEMIC PROGRESS
MEDICAL DOCUMENTATION FORM

Please print clearly—illegible documents cannot be processed

Student Name: ___________________________________ Campus ID: ______________________

I am requesting an appeal for the loss of Financial Aid eligibility for the following semester:

☐ Fall 2016  ☐ Spring 2017  ☐ Summer 2017

This form is required if you are appealing for one of the following reasons (check one):

☐ Disabling illness or injury to you (student)

☐ Disabling illness or injury of an immediate family member who required your care

☐ Emotional or mental health issue that required you to receive professional care

I give permission for my healthcare provider to supply all information necessary to respond to the questions listed below.

_______________________________________________  ______________________________________
Student/Patient Signature  Date

All items in the section below must be completed in full by a licensed healthcare provider.

1. Please provide the dates of the student’s/family member’s condition that prevented the student from attending school or completing class work.

From:_______________________________________________  To:__________________________________________________

2. Briefly describe the condition and how it prevented the student from attending school and/or completing class work. Use the back of this page is necessary.

______________________________________________________________________________________________________________________________________________

______________________________________________________________________________________________________________________________________________

______________________________________________________________________________________________________________________________________________

3. In your opinion, is the student able to return to school successfully at this time?

☐ YES: Recommended level of attendance:  ☐ Full-time (12 credits or more)  ☐ Part-time (less them 12 credits)

☐ NO: You do not recommend attendance at this time

☐ Unable to determine at this time: The student/patient will be released on __________________________(date).

Name/Address of healthcare professional:

______________________________________________________________________________________________________________________________________________

______________________________________________________________________________________________________________________________________________

______________________________________________________________________________________________________________________________________________

Please Print/Use Office Stamp

_______________________________________________  ______________________________________
Signature:___________________________________________  Phone:_______________________________________________

Professional Title:____________________________________  Date:________________________________________________

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